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**THE EVOLUTION OF THE MILITARY
HEALTH CARE BENEFIT (MHCB): THE
SCOPE OF THE CHANGES AND THE
PRINCIPAL DRIVERS BEHIND THEM**

by

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March 1997

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THE PRINCIPAL DRIVERS BEHIND THEM**

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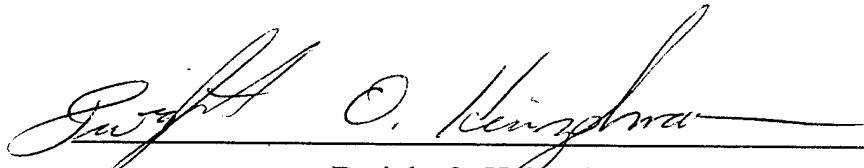
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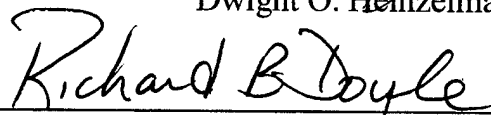
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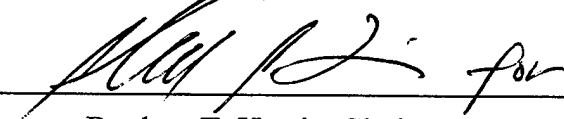
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This thesis examines the evolution of the Military Health Care Benefit (MHCB) and the principal factors that influenced its change. The Military Health Care Benefit is a critical part of the compensation package received by the military member. A detailed examination of United States Code, Title 10, along with congressional hearings, committee reports, legislative bills and external organizational literature was conducted. The congressional process for modifying the MHCB is explained, followed by identification and description of the major legislative changes to the MHCB between 1956 and 1996. Research revealed that the scope of the MHCB has dramatically increased since 1956. Three distinct periods of congressional action were identified. The first, 1956 to 1966, was characterized by establishment of the benefit structure and its initial expansion. The second, 1967 to 1982, was a "status quo" era in which Congress focused its attention on controlling the rising costs of CHAMPUS. The final period, 1983 to 1996, was dominated by congressional oversight, leading to further expansion of the MHCB and the development of Managed Care programs. Equity with private sector or other government sponsored health care programs was the primary factor in the growth of the MHCB. Understanding the process used to change the Military Health Care Benefit and the principal factors that influence this change allows planners an insight into possible future changes in military medical benefits and their associated costs.

TABLE OF CONTENTS

I.	INTRODUCTION	1
A.	BACKGROUND	1
B.	OBJECTIVE	2
C.	RESEARCH QUESTIONS	2
D.	SCOPE	3
E.	METHODOLOGY	3
F.	ORGANIZATION OF THE THESIS	3
II.	THE MILITARY HEALTH CARE BENEFIT	5
A.	OVERVIEW OF THE MILITARY HEALTH CARE BENEFIT	5
B.	CHAMPUS	8
C.	TRICARE	9
III.	HOW CONGRESSIONAL CHANGES TO THE MHCB ARE MADE	11
A.	OVERVIEW	11
B.	INTRODUCTION OF LEGISLATION AFFECTING THE MHCB	14
IV.	LEGISLATIVE HISTORY OF THE MILITARY HEALTH CARE BENEFIT FROM 1956 TO 1996	19
A.	OVERVIEW	19

B.	THE MHCB PRIOR TO 1956	19
C.	THE MHCB FROM 1956 TO 1966	20
1.	The Dependent's Medical Care Act of 1956	20
a.	Classification of Dependents	20
b.	Changes in Authorized Medical Care Benefits	21
c.	Medical Insurance Plan	22
2.	The Military Medical Benefits Amendments of 1966	23
a.	Classification of Dependents	23
b.	Changes in Authorized Medical Care Benefits	23
c.	Medical Insurance Plan (CHAMPUS)	24
D.	THE MHCB FROM 1967 TO 1982	25
1.	Classification of Dependents	25
2.	Changes in Authorized Medical Care Benefits	26
3.	Changes to the CHAMPUS Program	27
E.	THE MHCB FROM 1983 TO 1996	28
1.	Classification of Dependents	29
2.	Changes in Authorized Medical Care Benefits	30
3.	Changes to the CHAMPUS Program	31
4.	New Pilot Programs	33
F.	SUMMARY	33

V.	ANALYSIS OF THE MAJOR CHANGES TO THE MILITARY HEALTH CARE BENEFIT	35
A.	OVERVIEW	35
B.	FACTORS EXPLAINING THE PASSAGE OF THE DEPENDENTS' MEDICAL CARE ACT OF 1956	36
C.	FACTORS EXPLAINING THE PASSAGE OF THE MILITARY MEDICAL BENEFITS AMENDMENTS OF 1966	37
D.	FACTORS EXPLAINING THE "STATUS QUO" ERA OF 1967 TO 1982	39
E.	FACTORS EXPLAINING THE EXPLOSION OF LEGIS- LATIVE INITIATIVES AND DIRECTIVES FROM 1983 TO 1996	43
VI.	SUMMARY, CONCLUSIONS, AND FUTURE PROSPECTS	47
A.	SUMMARY	47
B.	CONCLUSIONS	49
C.	FUTURE PROSPECTS	52
D.	SUGGESTIONS FOR FUTURE RESEARCH	53
	LIST OF REFERENCES	55
	INITIAL DISTRIBUTION LIST	61

I. INTRODUCTION

A. BACKGROUND

Military health care can be divided into two major areas: (1) benefits for the active duty member, and (2) benefits for dependents and "certain former members" of the armed services. The latter refers to dependents of active duty personnel, retired members and their dependents, and in some cases, non-retired personnel. As stated in Title 10 of the United States Code, the purpose of the current law is "to create and maintain high morale in the uniform services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents" [Ref. 1:p. 669].¹

Over the past 40 years, and most notably since the 1960's, the Military Health Care Benefit (MHCB) for active duty members' dependents and certain former members and their dependents has evolved and expanded to become a major political issue. The MHCB was established by legislation. Oversight is conducted by the defense committees in Congress, i.e., Senate Armed Services, House National Security, Senate Defense Appropriations Subcommittee, and House National Security Appropriations Subcommittee. The factors that initiate changes to the MHCB derive from the multiple influences on these committees. These influences include: the changing American social environment, "carryover legislation" from Social Security, Medicare and Medicaid, the advent of an all volunteer military force, external forces (lobbyists and special interest groups/organizations), and a desire in Congress to "provide better than the minimum" for the military members, former members and their dependents.

¹The term "uniform services" refers to the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service.

However, another influence tends to operate in a different direction. Since the collapse of the former Soviet Union, a major influence on the defense committees has been the need to restrain defense spending. The MHCB has not been immune to this pressure.

B. OBJECTIVE

When the MHCB was born in 1799, it provided an "emergency care only" program for active duty members of the armed forces. Over the next two centuries, the MHCB has been under constant scrutiny and revision. The result has been development of a program of total medical coverage for active duty members and their dependents, retired members and their dependents, and in some cases, non-retired personnel.

This study will provide an in-depth review of the legislative changes to the MHCB from 1956 until 1996 in order to identify the principal drivers which influenced these changes. In addition, this study will provide insight into the future direction of the MHCB.

C. RESEARCH QUESTIONS

What are the principal factors that have influenced Congress to change the scope of the MHCB for active duty military, dependents and retirees?

What congressional process is used to change the MHCB?

In terms of the scope of the benefit, how has the MHCB evolved to its present day form?

What outside organizations have influenced congressional action on the MHCB?

Did changes in Social Security, Medicare and/or Medicaid influence corresponding changes in the MHCB?

What impact did shifting to an all volunteer military force have on the MHCB?

D. SCOPE

This study will examine the actions of Congress in modifying the MHCB from 1956 to 1996 by focusing on the defense committees. A year by year review will be conducted to identify significant changes to the MHCB. Where significant changes were made, an in-depth analysis of congressional intent and the forces involved will be conducted to determine the important elements involved in effecting these changes. In addition, each year will be reviewed to identify situations in which MHCB issues were discussed in Congress but not converted into legislation.

E. METHODOLOGY

The legislative history of the MHCB was reviewed from 1956 to 1996. The major source of information on the changes to the MHCB was Title 10 (Armed Forces) of the United States Code. Congressional hearings, committee reports, legislative bills and external organization literature (such as the American Association of Retired Persons (AARP), The Retired Officer Association (TROA), The American Red Cross, The American Legion, The American Medical Association (AMA), and numerous other associations and organizations) were also consulted to analyze the changes made to the MHCB.

F. ORGANIZATION OF THE THESIS

Chapter II provides a brief overview of the MHCB as it exists today. Chapter III provides a detailed review on the process involved for Congress to enact legislation affecting the MHCB. The focus will be on the defense committees and subcommittees. Chapter IV provides a detailed legislative history on the changes made to the MHCB from 1956 to 1996. Chapter V analyzes the significant changes identified from 1956 to 1996 to determine the principal drivers behind them. Chapter VI draws conclusions and provides insight into the future of the MHCB.

II. THE MILITARY HEALTH CARE BENEFIT

A. OVERVIEW OF THE MILITARY HEALTH CARE BENEFIT

The active duty military member, unlike his civilian counterpart, does not have to purchase health insurance for himself or his family.² Active duty members receive all required and/or needed medical care at no cost. This includes: hospitalization, physical examinations, infertility treatment, dental care, preventative measures such as immunizations, and any other medical care that would be expected to maintain the member's good health. Dependents of active duty members, along with former members (retirees) and their dependents, have different benefits and cost obligations, depending on their status.

All military beneficiaries can be treated at military treatment facilities (MTFs), free of charge, on a space available basis. Under current law, the priority for treatment at MTFs is as follows: the active duty member, the active duty member's dependents, retirees, and all other eligible personnel. The Navy, Army and Air Force operate approximately 100 hospitals and numerous other clinics throughout the world [Ref. 2:p. 3]. When these MTFs cannot provide the services required to all non-active duty eligible personnel, medical care and dental care can be obtained, depending on status, through several DoD programs. Medical care can be obtained at the nearest civilian medical treatment facility through either the Civilian Health and Medical Program for Uniform Services (CHAMPUS) or through a managed care program known as TRICARE.³

²The purchase of health insurance includes both private policies and benefits provided as part of employee compensation since both usually involve payment of a premium.

³TRICARE is currently available only in a few geographic regions. However, nationwide coverage, under 12 health service regions, will eventually be implemented by the Department of Defense.

Dental care for active duty military members is provided free at Dental Treatment Facilities (DTF). Dental care, for eligible dependents of active duty personnel, is provided through the TRICARE Family Member Dental Plan (TFMDP). The TFMDP is a private dental insurance plan offered through the Office of Civilian Health and Medical Program of the Uniform Services (OCHAMPUS). The plan provides diagnostic care, oral exams, and preventive care, with no co-payments to the eligible member. Other services are provided at various cost-share ratios.

The cost of the TFMDP is shared by DoD and the member. Active duty members pay a monthly premium for this program; however, DoD subsidizes the program, resulting in lower premiums for members. Currently there is no dental care insurance plan for retirees, their dependents, and other former members. This coverage is also summarized in Table 1.

To receive any medical and/or dental benefits from the Department of Defense, all eligible individuals must be enrolled in the Defense Eligibility and Enrollment Reporting System (DEERS). All active duty members and retirees are automatically enrolled, but dependents must be enrolled by the sponsor.

The term "dependent" with respect to a member or certain former members is defined as:

1. A spouse;
2. An unremarried widow or widower;
3. A child who has not attained the age of 21;
4. A child who has not attained the age of 23, if enrolled in a full-time course of study at an approved institution of higher learning, and is dependent on the member for over one-half of his support;

5. A child who is incapable of self-support due to a mental or physical incapacity that occurred within the 21 and 23 age guidelines as listed above;
6. A parent or parent-in-law who is, or was at the time of death of the member or former member, dependent on the member for over one-half of his support and who resided with the member;
7. An unremarried former spouse of a member or former member who performed at least 20 years of service and had been married to the member for at least 15 of those years who does not have medical coverage under an employer sponsored health plan. [Ref. 3:pp. 670-671]

Table 1. Military Health Care Benefit Available Under Current DoD Programs [Ref. 3]

	MTF	CHAMPUS/TRICARE		Dental Care	
Beneficiary	Inpatient & Outpatient	Inpatient	Outpatient	DTF	TFMDP
Active duty member	Yes	No	No	Yes	No
Dependents of active duty members	Yes, on a space available basis	Yes	Yes	Yes, on a space available basis	Yes
Retirees and their dependents	Yes, on a space available basis	Yes, but only until Medicare eligible at age 65	Yes, but only until Medicare eligible at age 65	Yes, on a space available basis	No
Certain former spouses	Yes, on a space available basis	Yes, but only until Medicare eligible at age 65	Yes, but only until Medicare eligible at age 65	Yes, on a space available basis	No
Dependent parents, parents-in-law, pre-adoptive children	Yes, on a space available basis	No	No	Yes, on a space available basis	No

B. CHAMPUS

CHAMPUS is a health insurance plan that reimburses for health care services provided by civilian doctors to all eligible members. Congress created CHAMPUS in 1966 to augment the MTFs and to provide services to dependents of active duty members along with former members and their dependents in areas not covered by a MTF. However, with the closure of many MTFs due to the drawdown, CHAMPUS has become the major program of the MHCB provided to all non-active duty eligible members.

CHAMPUS allows eligible members to freely choose outpatient care (when overnight stay in a hospital or medical facility is not required) from civilian providers with very few restrictions. When inpatient care (when overnight or a longer stay in a hospital or medical facility is required) is needed, the eligible member must have prior approval (except in the case of emergencies) from CHAMPUS.

Under CHAMPUS, all medical expenses are paid using a combination of standard deductibles, co-pays, and cost-share ratios. The amount that CHAMPUS will cover depends on the following:

1. Whether care is provided in an outpatient or inpatient status;
2. Whether the provider participates in the CHAMPUS program;
3. The sponsor's status (Active duty dependents pay a different ratio than retirees and their dependents, dependents of deceased service members, and eligible former military spouses).

To protect the financial security of the member, the amount of out-of-pocket costs that the member is responsible for is limited for any fiscal year. This limit or "cap" applies only to the amount of money required to meet the member's annual

deductibles and cost-share amounts. It does not include costs of services not covered by CHAMPUS.

Generally, CHAMPUS covers most health care that is medically necessary for the eligible individual. However, there are limits on certain types of care that CHAMPUS will cover and some types of care are not covered at all. In addition, when the eligible member attains the age of 65, CHAMPUS eligibility automatically ends and Medicare coverage begins.

C. TRICARE

The DoD's managed health care plan, TRICARE, offers three options to all CHAMPUS eligible members. Members can choose from the following options: TRICARE Standard, Prime and Extra.

TRICARE Standard: This program was modeled after the existing CHAMPUS benefit. Members are free to choose the health care provider of their choice, but they pay the standard deductibles, co-pays, and cost-share amounts.

TRICARE PRIME: This program was modeled after the Health Maintenance Organizations (HMO) found in the private sector. Members enroll in a HMO plan and obtain their health care from an authorized network of providers. Active duty dependents are enrolled free of charge; however, all other eligible members are required to pay an annual enrollment fee. As with an HMO, a member selects a primary physician, known as a Primary Care Manager (PCM). The PCM is the physician that the member must visit first for all treatment. If the PCM decides that the member needs further treatment or service from another provider, the member will be referred to the most appropriate care available. TRICARE Prime does have a provision to allow the member to obtain health care services outside the network; however, the member will be responsible for a deductible and a higher member cost-share with limits on the amount CHAMPUS will cover.

TRICARE Extra: This program works in conjunction with TRICARE Standard. Under TRICARE Extra, the member has the same benefits, but at a lower cost, as offered through the standard program. However, to receive these savings, the member agrees to use the same health care providers as offered under TRICARE Prime. This program also offers flexibility to the member by allowing him to use the TRICARE Standard benefit, using the standard program's cost structure.

III. HOW CONGRESSIONAL CHANGES TO THE MHCB ARE MADE

A. OVERVIEW

The fundamental responsibility of Congress is lawmaking. Congress's central role in policy formulation originates in the Constitution. The writers of the Constitution, Madison, Hamilton, and others, developed a political system that established Congress as the lawmaking body. As stated in Article I, Section 1, of the United States Constitution, "all legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives." Several basic principles underlie the specific provisions of the Constitution. These principles include limited government, separation of powers, checks and balances, and federalism. The provisions established by the framers of the Constitution continue to shape lawmaking today, despite the enormous changes that have occurred in the role of government in American society. [Ref. 4:pp. 1-2]

Congress, like all decision-making bodies, needs a set of rules and procedures in order to function. These rules and procedures establish the procedural context for policy-making action. Article I, Section V, of the Constitution authorizes the House and Senate to formulate their own rules of procedure and also prescribes some basic procedures for both bodies. [Ref. 4:p. 5]

In any organization, rules and procedures serve many functions. They provide "stability, legitimize decisions, divide responsibilities, reduce conflicts, and distribute power." [Ref. 4:p. 5] For Congress, committees are the heart of the legislative process. They provide the division of labor and specialization that Congress needs to handle its vast workload. Like specialized bodies in many organizations, committees do not make final policy decisions but initiate recommendations that are forwarded to their respective chambers.

The jurisdiction of Congress's standing committees is outlined in the House and Senate rules. Legislation generally is referred to committee (or committees) having authority over the subject matter. As a result, the rules generally determine which committee(s), and thus which members and their staffs, will exercise significant influence over a particular issue such as Defense. Once legislation is referred to committee, it can be further divided and referred to various subcommittees such as Military Personnel and Readiness. [Ref. 5:pp. 2-3]

The committees or subcommittees then conduct hearings on the pending legislation. These hearings provide a forum for comment from various stakeholders inside and outside of government. These stakeholders include: federal agencies, lobbyists or special interest groups, private citizens and numerous associations representing the needs of their members. [Ref. 9:p. 2]

Committee and subcommittee hearings provide members of Congress with the information needed to make informed decisions on the legislation. In addition, hearings help to provide the political support the members need to enact legislation, especially with controversial issues. This process allows members of Congress to determine which of their constituents has a vested interest in the pending legislation, and the potential political "fall-out" of their decisions.⁴ [Ref. 4:pp. 109-112]

After hearings are completed, the committee or subcommittee conducts a "mark-up" session. This process allows the views of all committee or subcommittee members to be heard prior to the committee action on the legislation. Once the "mark-up" is completed, the committee or subcommittee votes on the pending legislation. The following are the possible actions of the committee or subcommittee:

⁴The term "constituents" includes both individuals and groups represented by the member from his or her home state or district, and individuals and groups represented by the member's assignment to various committees and subcommittees.

1. Report the legislation favorably to the committee (in the case of a subcommittee), or to the full House or Senate (in the case of a committee);
2. Report the legislation favorably, with amendments;
3. Report the legislation without recommendation or unfavorably;
4. Recommend action on the legislation be postponed indefinitely.

In all cases, except when the recommendation is to postpone legislation indefinitely, the committee prepares a written report on the legislation. This committee report details the purpose and scope of the legislation and the reasons behind the committee's decision. The report provides for both supporting and opposing views to be included. The committee report is then sent to the full House or Senate for consideration or "floor action." [Ref. 8:p. 13]

Floor action is the process of legislation being reported to the House or Senate for general debate. This debate allows for both the majority and minority opinion to be heard prior to a full House or Senate vote. In addition, it provides additional information to the member prior to his or her vote. If legislation is passed, it then goes to the opposing chamber of Congress for consideration. [Ref. 6:p. 4]

Once the House or Senate receives legislation from the opposing chamber, two avenues of action can occur. First, if the legislation is simple and routine, it can be passed without amendment and sent to the President for consideration. Secondly, the most common practice is to introduce the legislation to committee and start the entire legislative process again (in some cases, both the House and Senate initiated similar legislation simultaneously; therefore the second chamber acts on its own legislation instead of acting on the opposing chamber's) [Ref 6:p. 4]. The result will be legislation that is amended from the original version. Before legislation can be sent

to the President for consideration, it must be passed by both the House and Senate in identical form. When the two versions differ, the legislation is then sent to the House-Senate conference committee to negotiate a compromise.

The House-Senate conference committee is an ad-hoc committee that forms whenever there are differences in the House and Senate versions of the legislation. The conference committee consists of selected members of the committees responsible for the legislation. Their task is to negotiate and work out a compromise on the legislation that both chambers can support. After the compromise is agreed to, the legislation is voted on by both the House and Senate. If both the House and Senate approve the legislation, it then goes to the President for consideration. A summary of the legislative process is shown in Figure 1. [Ref. 6:pp. 16-20]

B. INTRODUCTION OF LEGISLATION AFFECTING THE MHCB

All legislation must be formally introduced by members of Congress. However, this does not imply that congressional members are the initial source of all legislation. In fact, few legislative proposals are conceived and drafted by the individual member. The majority of legislative proposals affecting the MHCB are proposed by a member's constituents, health and retirement associations, military coalitions, and federal agencies of the executive branch. These stakeholders communicate their ideas, or in many cases provide their desired legislation, directly to the member by right of petition. [Ref. 8:p. 4]

Once a member decides to initiate legislation that affects the MHCB, the usual action is to introduce a bill which addresses the member's proposal. This bill will be one of two types: authorization or appropriation. An authorization bill establishes or continues programs and policies; whereas, an appropriation bill provides the actual funds to those authorized programs [Ref. 7:p. 208]. In the area of Defense and the MHCB, this bill will be referred to the appropriate committees and subcommittees

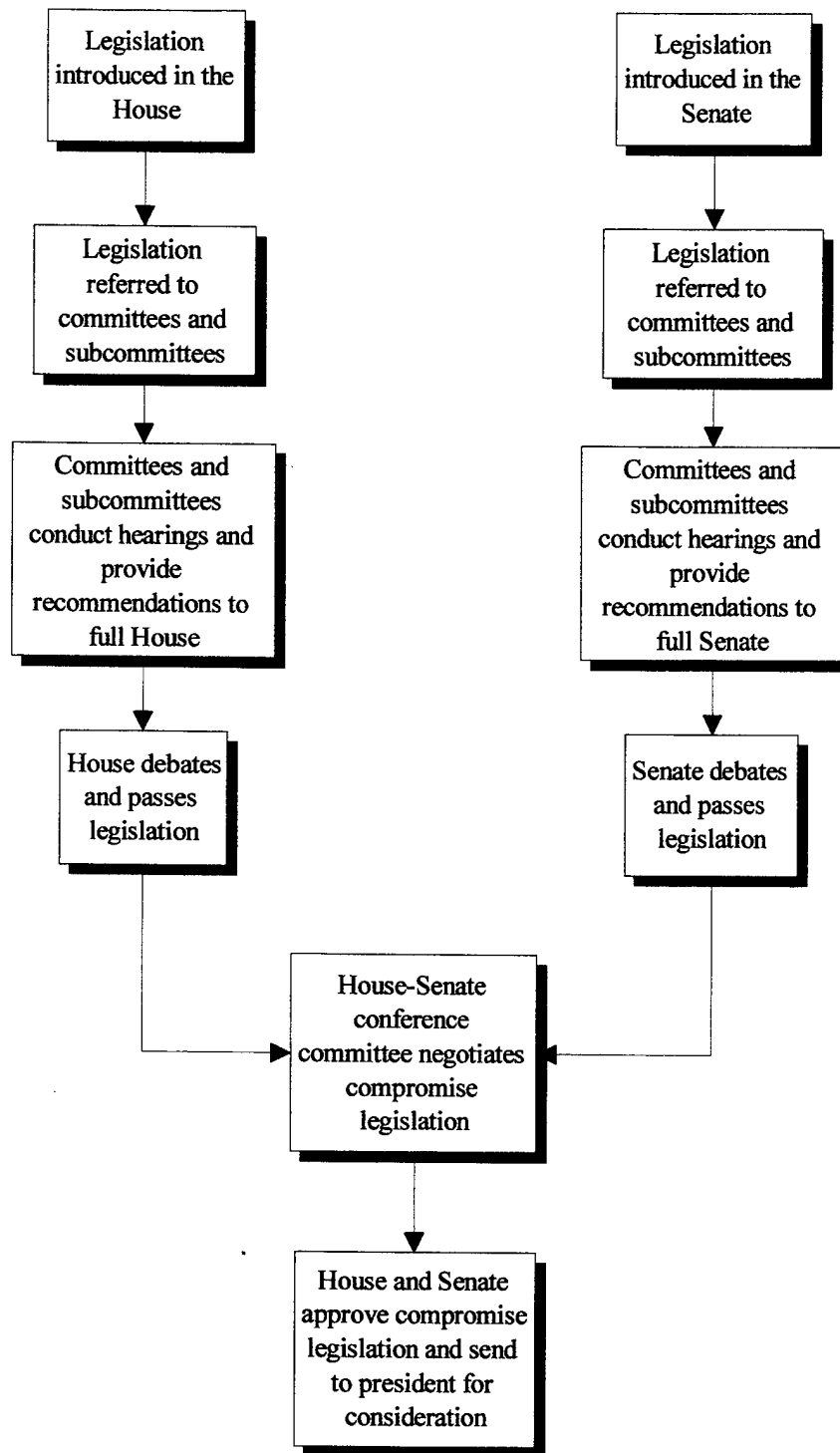


Figure 1. Summary of the Congressional Legislative Process

in the House and Senate. In the House, an authorization bill concerning the MHCB will be referred to the National Security Committee, to be addressed by the subcommittees on Military Personnel and Military Readiness. An appropriation bill concerning the MHCB will be referred to the Appropriations Committee, where the subcommittee on National Security will take responsibility for it.

In the Senate, an authorization bill concerning the MHCB will be referred to the Armed Services Committee, and the subcommittees on Personnel and Readiness will be the principal players. An appropriation bill concerning the MHCB will be referred to the Appropriations Committee, and then addressed by the subcommittee on Defense. Table 2. provides a summary of committee and subcommittee referral for issues pertaining to the MHCB. [Ref. 10:pp. 32-34]

Table 2. Congressional Committee and Subcommittee Referral for DoD Issues Concerning Military Health Care Benefits

Type of Bill	House		Senate	
	Committee	Subcommittee(s)	Committee	Subcommittee(s)
Authorization	National Security	Military Personnel Military Readiness	Armed Services	Personnel Readiness
Appropriation	Appropriations	National Security	Appropriations	Defense

Once the various defense subcommittees receive the bill, hearings are scheduled to investigate the matter. The House and Senate subcommittees will hear testimony from numerous stakeholders affected by the issue. After these hearings, the subcommittee members will review the legislation in detail and mark-up the bill. If the subcommittee reports on the bill are favorable, they will include it as an amendment to the overall Defense Authorization or Appropriations Bill for consideration by the full committee. Once referred to the full committee, the

committee can either accept the bill as is, or in some cases, conduct further hearings and/or meetings to add or modify amendments.

Some issues concerning the MHCB go beyond the jurisdiction of the defense committees and subcommittees. These issues usually involve programs and/or entitlements that other committees or subcommittees control. Examples of these include: the House and Senate Veteran's Affairs Committees, which control the benefits that affect veterans programs, and the Senate Finance Committee which controls Medicare. When several committees have jurisdiction, the following events can occur: 1) behind the scenes negotiations between committee members will decide which amendments are added, deleted or modified and, whether the bill is recommended for floor action, or 2) the bill will be referred to several committees each responsible for holding hearings and reporting legislation. [Ref. 10:pp. 31-40]

On the floor of the House and Senate, changes to the MHCB are now incorporated within the Defense Appropriations and Authorization Bills. These bills will undergo debate and will, in many cases, be amended to reflect the Full House's or Senate's desires for passage. Here changes to the MHCB can be supported or dropped due to congressional conflict.

After passage of the Defense Appropriations and Authorization Bills in both the House and Senate, conference committees will be formed with members from the defense committees and subcommittees. These conference committees will negotiate a compromise between the House and Senate versions. Representatives from the executive branch and association and coalition lobbyists attempt to "provide input" about possible compromises to sway the members to their cause. The final conference legislation is then voted on by the Full House and Senate. Whether it contains changes to the MHCB is largely depended on the relative bipartisan support the issue had. [Ref. 9:p. 8]

The compromise Defense Appropriations and Authorization Bills, or conference agreements, are then voted on by both chambers. Once passed by the House and Senate, the bills are sent to the president for consideration. The President can take any of the following actions:

1. Sign the bill into law;
2. Take no action, in which case the bill automatically becomes law;
3. Veto the bill and return it to Congress. Congress may attempt to override the President's veto with a two thirds majority vote in both chambers or Congress will modify the bill to make it acceptable to the President;
4. Exercise the authority to veto a single line item in the bill, beginning in 1997. [Ref. 9:p. 9]

IV. LEGISLATIVE HISTORY OF THE MILITARY HEALTH CARE BENEFIT FROM 1956 TO 1996

A. OVERVIEW

This chapter provides a detailed legislative history of the MHCB from 1956 to 1996. During this 40 year time-span, three distinct periods can be seen in the evolution of the MHCB. The first period covers the 10 years between 1956 and 1966 and contains the two major legislative initiatives that form the basis of the modern day MHCB. The second period, spanning the 16 years between 1967 and 1982, represents a "status quo" era during which congressional concerns with the growing cost of the CHAMPUS resulted in minor legislation restricting the use of the CHAMPUS benefit. The final period, from 1983 to 1996, is characterized by an explosion of legislative initiatives and directives increasing the benefits available to beneficiaries.

B. THE MHCB PRIOR TO 1956

Health care benefits provided to the active duty member included all required and/or needed medical care at no cost. This included hospitalization, preventative care, dental care, and any other medical care that was required to maintain the member's good health. However, medical care for dependents of active duty members was very limited prior to 1956, and there was no provision for medical care to retired personnel or their dependents.

The designation "dependent" was limited to a lawful wife, an unmarried dependent child under 21 years of age, and the parents of the member (if in fact, the parents were dependent on the member). In addition, the widows of deceased members were entitled to the same medical benefits as dependents. Dependent medical care would be provided in MTFs only if adequate care was not available in private sector facilities. The only benefits available to the active duty dependent were

for acute medical and surgical conditions, excluding nervous, mental, or contagious diseases or those requiring domiciliary care. Dental care was not provided unless required by the hospitalization. [Ref. 11]

C. THE MHCB FROM 1956 TO 1966

The largest increase in the scope of the MHCB occurred between 1956 and 1966 with two major increases occurring as a result of legislation passed in 1956 and 1966. In June of 1956, Congress passed Public Law 84-569, "the Dependents' Medical Care Act." The purpose of this act was to "create and maintain high morale throughout the uniform services by providing an improved and uniform program of medical care for members of the uniformed services and their dependents." [Ref. 12:p. 250] This act expanded the definition of dependents, provided medical and dental care to retirees, increased the type of medical care available, and established a dependent insurance program.

1. The Dependent's Medical Care Act of 1956

a. Classification of Dependents

Prior to 1956, very few individuals met the qualification as an eligible dependent to receive medical benefits. The Dependents' Medical Care Act of 1956 changed the classification of a "dependent" to include any person who bears to an active duty member, retired member, deceased member, or a deceased retired member any of the following relationships:

1. A lawful wife;
2. A lawful husband, if dependent on the member or retired member for over one-half of his support;
3. An unremarried widow;

4. An unremarried widower, if he was dependent on the member or retired member at the time of her death for over one-half of his support because of a mental or physical incapacity;
5. An unmarried legitimate child who has not attained the age of 21;
6. An unmarried legitimate child who has not attained the age of 23, if enrolled in a full-time course of study at an approved institution of higher learning, and is dependent on the member or retired member for over one-half of his support;
7. An unmarried legitimate child greater than 21 years of age who is incapable of self-support due to a mental or physical incapacity that existed prior to attaining the age of 21;
8. A parent or parent in-law who is, or was at the time of death of the member or retired member, dependent on the member for over one-half of his support and who resided with the member.

b. Changes in Authorized Medical Care Benefits

The Dependents' Medical Care Act also increased both the type of services that were authorized to beneficiaries and changed the rules governing eligibility for these benefits. Prior to 1956, outpatient care was not authorized for any dependents, and only an active duty military dependent could receive inpatient care in a MTF limited to acute medical and surgical conditions. This act authorized outpatient services for all beneficiaries, along with the following types of medical care, in addition to acute medical and surgical conditions, at MTFs on a space available basis: treatment of contagious diseases, diagnosis of illnesses, immunizations, and maternity to include infant care. Not only were active duty dependents covered by this act, but also retirees and their dependents. The only exception was that dental care would only be provided to active duty and retired

members at DTFs. Dependent dental care would only be provided at MTFs when required as a result of hospitalization.

c. Medical Insurance Plan

The Dependents' Medical Care Act created an insurance plan, later known as Dependent Medicare, completely funded by the government for dependents of active duty members (retirees and their dependents were not included). The dependent had "free choice" in choosing a MTF or a private civilian provider. However, only designated services were covered under this plan. These services were restricted to:

1. Hospitalization and all necessary services and supplies for up to 365 days for each admission;
2. Medical and surgical care incident to hospitalization;
3. Maternity and obstetrical care including prenatal and postnatal care;
4. Physician or surgeon visits prior to and following hospitalization;
5. Diagnostic tests and procedures required due to hospitalization;

The act specifically prohibited the following services:

1. Hospitalization for domiciliary care;
2. Hospitalization for nervous conditions and mental disorders, chronic diseases, or elective medical and surgical treatments except in "special and unusual cases;"⁵

⁵Congress did not define "special case" and let that be at the discretion of the medical community.

3. Prosthetic devices, hearing aids, orthopedic footwear, and spectacles except in remote locations where adequate care is unavailable;
4. Ambulance service, except in acute emergency;
5. House visits, except when medically required by the physician or surgeon;
6. Dental care, except when required due to hospitalization and in remote locations where adequate care is unavailable. [Ref. 12]

Although the Dependents' Medical Care Act significantly improved the benefits received by most dependents, serious shortfalls still existed. But from 1957 to 1965 only one change affecting dependent health care became law. Public Law 89-140 provided for free transportation to medical facilities for dependents stationed outside of the United States [Ref. 13]. The most sweeping change to the MHCB occurred in September 1966 with the passage of Public Law 89-614, "Military Medical Benefits Amendments of 1966." The act provided several major changes to the MHCB.

2. The Military Medical Benefits Amendments of 1966

a. Classification of Dependents

The Military Medical Benefits Amendments of 1966 reduced the scope of coverage by eliminating from this category dependents of deceased members who were not entitled to retired pay at time of death, thus eliminating all medical benefits to those individuals.

b. Changes in Authorized Medical Care Benefits

The Military Medical Benefits Amendments of 1966 enhanced the benefits provided in the Dependents' Medical Care Act of 1956 by adding treatment of nervous, mental, and chronic conditions, routine physical examinations, annual eye

examinations, and usage of artificial limbs and eyes. This legislation also authorized ambulance service and house visits when medically required and provided durable equipment, such as wheelchairs and hospital beds, on a loan basis.

Another increase in the scope of the MHCB was the entitlement to dental care. The Dependents' Medical Care Act of 1956 authorized dental care for only active duty and retired personnel. The Military Medical Benefits Amendments of 1966 further expanded this benefit and authorized dental care for active duty and retired members dependents at DTFs on a space available basis. This marked the first time that dependent dental care was available on a non-inpatient basis.

c. Medical Insurance Plan (CHAMPUS)

The Military Medical Benefits Amendments of 1966 directed DoD to establish a medical insurance program (this program would later be referred to as CHAMPUS) that would guarantee medical care to all active duty dependents, retired members, and their dependents when MTFs were unavailable. This program would provide the same benefits that the dependents would be eligible for at MTFs with the following exceptions:

1. Dental care would only be authorized when required due to hospitalization;
2. Physical examinations and immunizations would only be authorized when the member and his dependents traveled outside of the United States on official duty;
3. Routine care of newborn, well-baby care, and eye examinations were not authorized;
4. Durable equipment such as wheelchairs and hospital beds could be provided on a rental basis;

5. A mentally retarded or seriously handicapped dependent of an active duty member was authorized the following additional services with regard to his or her condition: diagnosis, inpatient and outpatient treatment, home treatment, training, rehabilitation, special education, institutional care in private facilities, and transportation to and from these facilities. The cost of this special program would be shared between the government and member for services received;
6. All beneficiaries under this program would become ineligible for benefits at age 65 if they were entitled to hospital insurance benefits under the Social Security Act of 1965. [Ref. 14]

The structure of the modern day MHCB was formed with the passage of these amendments and the Dependents' Medical Care Act of 1956. These two acts formed the basis of all dependent care for active duty military members and their dependents, and former members and their dependents. The benefits they provided turned a near non-existent health care program (prior to 1956) into one of the most generous programs available to any American [Ref. 15].

D. THE MHCB FROM 1967 TO 1982

Between 1967 and 1982 there was very little change in the MHCB. Exceptions included the repeal of certain gender-based differences in the treatment of dependents, continued coverage for certain dependents of members who died on active duty, authorization to provide a wig to certain members and their dependents, along with former members and their dependents, and restrictions on CHAMPUS benefits.

1. Classification of Dependents

Until 1980, status as a military dependent was based on gender. A wife of a member or retired member was always a dependent; however, a husband was a dependent only if he received over one-half of his support from his wife. In the same manner, an unremarried widow was a dependent; however, a unremarried widower

could only be a dependent if he was mentally or physically incapacitated and he received over one-half of his support from his wife. [Ref. 12]

In 1980, Congress passed Public Law 96-513, the "Defense Officer Personnel Management Act." This act removed the gender-based terms of "wife" and "husband" and replaced them with "spouse." In addition, financial support requirements and mental or physical disabilities were repealed for the spouse of a female member or retired member. [Ref. 16]

Eligibility for military dependency status was further expanded in 1982. Public Law 97-252, "Department of Defense Appropriation Act, 1983," authorized medical and dental coverage for an unremarried former spouse of a member or former member who met the following two conditions:

1. Was married to the member or former member for at least 20 years in which the member or former member was on active duty;
2. Does not have medical coverage under an employer-sponsored health plan. [Ref. 17]

2. Changes in Authorized Medical Care Benefits

The Military Medical Benefits Amendments of 1966 eliminated medical coverage for all dependents of deceased members if they died prior to entitlement of retired pay. Congress partially restored this benefit with the passage of Public Law 92-58 of 29 July 1971. This statute provided for the continued coverage of a mentally retarded or seriously handicapped dependent (until age 21) of an active duty member who died prior to entitlement of retired pay, provided the member died while eligible for hostile fire pay. This act was made retroactive to January 1967 to cover all personnel since the passage of the Military Medical Benefits Amendments of 1966. [Ref. 18]

In 1982, Congress granted the authority for DoD to provide a wig to certain members and their dependents, along with former members and their dependents. Public Law 97-377, "Joint Resolution on Appropriations for Fiscal Year 1983," stated that eligible beneficiaries who have alopecia (baldness) that resulted from treatment of a malignant disease would be provided one wig. [Ref. 19]

3. Changes to the CHAMPUS Program

When Congress first authorized DoD to provide for an insurance program for dependents of active duty members, and former members and their dependents, Congress directed DoD to establish the guidelines for determining when services were not available at a MTF. This resulted in the "non-availability statement" which authorized medical care for the beneficiary at a civilian hospital when services at a MTF were unavailable. However, the determination of non-availability was not uniform throughout or even within the services.

In 1976, Congress established guidelines for DoD. Public Law 94-212, "Department of Defense Appropriation Act, 1976," prohibited CHAMPUS payments for non-emergency inpatient hospital care at civilian facilities when treatment was available at a MTF within a 40 mile radius of the beneficiary. In addition, Congress further defined services which would not be authorized as a CHAMPUS benefit. These unauthorized services included:

1. Pastoral, marital, family and child counselors when similar services are available within 40 miles of the beneficiary;
2. Special education, except when required as an institutional inpatient service;
3. Therapy or counseling for sexual dysfunctions;
4. Treatment of obesity;
5. Reconstructive surgery to satisfy psychological needs. [Ref. 20]

Over the next six years (1976-1982), the only changes Congress made to the CHAMPUS benefit were minor changes to the above unauthorized services. These changes included:

1. Public Law 94-419, "Department of Defense Appropriation Act, 1977," deleted the 40 mile radius as a condition to receive counselor services and stipulated that these services would be authorized if directed by a medical doctor [Ref. 21];
2. Public Law 95-111, "Department of Defense Appropriation Act, 1978," prohibited reimbursement for medical care in excess of the seventy-fifth percentile of the customary charges made for similar services in the location where the services were performed [Ref. 22];
3. Public Law 95-457, "Department of Defense Appropriation Act, 1979," increased the prohibition on medical care reimbursement from the seventy-fifth to the eightieth percentile [Ref. 23];
4. Public Law 97-114, "Department of Defense Appropriation Act, 1982," modified the restriction on reconstructive surgery and authorized reconstructive surgery for mastectomy and other serious deformities caused by congenital anomalies, accidental injuries and neoplastic surgery [Ref. 24];
5. Public Law 97-377, "Joint Resolution on Appropriations for FY 1983," modified the prohibition of CHAMPUS payments within a 40 mile radius. This act authorized payments within 40 miles if the payments were supplemental to the beneficiary's private insurance plan and that this plan covered at least seventy-five percent of the cost. [Ref. 25]

E. THE MHCB FROM 1983 TO 1996

The year 1983 initiated a new era in the growth of the MHCB. Since 1966, only minor modifications had been made to the MHCB; however, with the passage

of Public Law 98-94, Defense Authorization Act of FY 84, Congress directed DoD to

conduct studies and demonstration projects on the health care delivery system of the uniformed services with the view to improving the quality, efficiency, convenience, and cost effectiveness of providing health care services (including dental care services) to members and former members and their dependents. [Ref. 26]

These studies and projects would lead to new programs and benefits for eligible beneficiaries. Modifications addressed the classification of dependents and the type of health services available under CHAMPUS.

1. Classification of Dependents

Until 1984, the divorced former spouse of a member eligible to receive retired pay had to be married to the member for at least 20 years during which the member served on active duty in order to be classified as a dependent and therefore receive medical benefits. Congress modified this requirement with Public Law 98-525, "Department of Defense Authorization Act, 1985." This act stated that the spouse still needed to be married to the member for at least 20 years; however, only 15 of those years had to be while the member was on active duty. [Ref. 27]

In 1993, Congress closed a gap in the classification of a dependent with a mental or physical incapacity. Public Law 102-484, "National Defense Authorization Act, 1993," stated that if the mental or physical incapacity of a dependent child occurred between the ages of 21 and 23, while the dependent was enrolled in a full-time course of study at an approved institution of higher learning, the child would remain a dependent as long as he was dependent on the member for over one-half of his support [Ref. 28]. Previously, the incapacity had to exist prior to the dependent child attaining 21 years of age.

The final changes to dependency status occurred with the passage of Public Law 103-337, "National Defense Authorization Act, 1995." This act classified a pre-adoptive child as a dependent if the child was placed in the home of the member by an approved adoption agency for the purpose of adoption; however, the act further stipulated that a pre-adoptive child would not be eligible to receive benefits under CHAMPUS. [Ref. 29]

The National Defense Authorization Act also authorized medical and dental care for dependents of members who died while on active duty; however, the dependents would only be eligible for these benefits for one year from the date of death of the member.⁶

2. Changes in Authorized Medical Care Benefits

In 1983, Congress authorized the first organ transplant to be covered under the military health plan. Public Law 98-94, "Department of Defense Authorization Act, 1984," authorized liver transplants when required. [Ref. 26]

Eye examinations under CHAMPUS were made available to dependents of active duty members with the passage of Public Law 98-525, "Department of Defense Authorization Act, 1985." [Ref. 27]

One of the most important increases in the MHCB occurred in 1985. Public Law 99-145, "Department of Defense Authorization Act, 1986," established the Dependents Dental Program for dependents of active duty members. This program is a private insurance program in which DoD and the member share in the cost of the monthly premium. The dependents of active duty members would receive routine care to include diagnostic, oral examination, preventative services, and palliative emergency care with no co-payments. Select special services such as basic

⁶These members are those who are not eligible for retired pay, or were not killed in an area designated as a hostile fire zone.

restoration, crown and dental appliance repairs, would be cost-shared, with the member paying 20 percent and the remaining 80 percent paid by the government. However, the member was responsible for the full cost of services not covered under the plan. [Ref. 30]

The Dependents Dental plan was enhanced in 1993 when Congress directed DoD to provide a supplemental dental insurance plan for eligible beneficiaries [Ref. 31]. This was the result of Public Law 102-484, "National Defense Authorization Act, 1993." This act expanded the services provided to the eligible beneficiary. Routine care was still provided with no co-payments; however, all other services were provided on various cost-share ratios depending on the type of service received. [Ref. 28]

Women's health care benefits were improved in 1990 with the passage of Public Law 101-510, "National Defense Authorization Act, 1991." This act authorized pap smears and mammograms on a diagnostic or preventative basis. Previously these tests could only be done in conjunction with an illness. However, the major increase in women's health benefits occurred in Public Law 103-160, "National Defense Authorization Act, 1994." This act provided for complete primary and preventative health care for women. This included counseling, pap smears, breast examinations, mammography, obstetrical and gynecological care, pregnancy and pregnancy prevention, infertility, menopause, sexually transmitted diseases, and physical and psychological conditions from acts of violence. [Refs. 32 and 33]

3. Changes to the CHAMPUS Program

Public Law 99-661, "National Defense Authorization Act, 1987," set the stage for sweeping changes in the way the MHCB was managed and how the services were received by the beneficiary. In this act, Congress directed DoD to develop programs in order to increase the efficiency and to reduce the cost of CHAMPUS. Referred to

as "the CHAMPUS Reform Initiative," DoD was required to implement reforms in the administration and delivery of CHAMPUS medical benefits, while not reducing the benefits authorized by Congress. In addition, DoD was directed to develop a project for managed care, similar to private health maintenance organizations, in order to reduce the costs of CHAMPUS. The CHAMPUS Reform initiative developed into the current CHAMPUS, TRICARE Standard and TRICARE Extra medical benefit programs. The managed care program evolved into the current TRICARE Prime program being implemented throughout the nation. [Ref. 34]

In an attempt to limit the out-of-pocket expenses of members and former members in the event of catastrophic situations, Congress established "caps" on the amount the member would have to pay under CHAMPUS. Public Law 100-180, "National Defense Authorization Act, 1988 1989," set a limit of one thousand dollars for active duty members and their dependents, and ten thousand dollars for all other beneficiaries [Ref. 35]. Congress later modified the limit on all other beneficiaries to seven thousand five hundred dollars [Ref. 28].

In 1990, Congress repealed the restriction on providing certain counseling benefits without direction from a medical doctor. Public Law 101-510, "National Defense Authorization Act, 1991," authorized CHAMPUS coverage of all services received from "certified" counselors. This same statute attempted to limit the cost of mental health services by restricting the benefits available to eligible beneficiaries. These limits included a 30 day maximum treatment for beneficiaries 19 and over, 45 days for those 18 and under, and a 150 day maximum for resident treatment care. However, these limits did not apply if the beneficiary was mentally retarded or seriously handicapped. [Ref. 32]

In 1996, Congress removed all previous restrictions on immunizations and routine physical examinations. Public Law 104-106, "National Defense Authorization

Act, 1996," provided immunizations and routine physical examinations to all eligible beneficiaries. [Ref. 36]

4. New Pilot Programs

Congress has directed DoD to develop several pilot programs to improve the health care available to all beneficiaries. These programs are in the developmental stage and have not been authorized for implementation. These programs include:

1. Providing comprehensive chiropractic care at MTFs [Ref. 29];
2. Developing a Dental Plan for members of the selected reserve of the ready reserve;
3. Developing a pilot program for residential care of emotional disturbed children;
4. Developing a program to allow Medicare beneficiaries access to CHAMPUS/TRICARE. [Ref. 36]

F. SUMMARY

From 1956 to 1996, the MHCB evolved from a nearly non-existent health care program for dependents and retirees into a generous and comprehensive system. In 1956, Congress reacted to the lack of health care for military dependents by significantly increasing its role in health care legislation. This role steadily increased, beginning with the Dependents' Medical Care Act of 1956 and the passage of the Military Medical Benefits Amendments of 1966. These two legislative acts provided fundamental changes to the MHCB resulting in a solid foundation for health care coverage for the families of active duty members and retirees along with their dependents. The next phase of legislation focused on the rising cost of the CHAMPUS program and provided restrictions on the benefit in order to control costs.

In 1983, congressional involvement returned to increasing benefits to eligible beneficiaries. Table 3 provides a timeline of the significant events in the evolution of the MHCB.

Table 3. THE EVOLUTION OF THE MILITARY HEALTH CARE BENEFIT

	Benefit Establishment			Cost Control	Benefit Expansion and Managed Care	
	1955	1956	1966	1967-1982	1985	1986-1996
MILESTONE						
Active duty dependents eligible for inpatient treatment at MTFs for acute conditions						
Classification of dependents significantly expanded						
Inpatient and outpatient care authorized for active duty dependents, retirees and their dependents at MTFs						
Dental care authorized for retirees at DTFs						
Dependent Medicare established for active duty dependents						
Dental care authorized for dependents of active duty and retired members at DTFs						
CHAMPUS established for active duty dependents, retirees and their dependents						
Congress focuses on controlling the rising cost of CHAMPUS						
CHAMPUS coverage prohibited when treatment is available within a 40 mile radius of the beneficiary						
Dependents Dental Program established for active duty dependents						
Complete primary and preventative health care for women authorized						
TRICARE established						
Restrictions on immunizations and physical examinations removed						

V. ANALYSIS OF THE MAJOR CHANGES TO THE MILITARY HEALTH CARE BENEFIT

A. OVERVIEW

Historically, the purpose of the MHCB has been to provide compensation for the unique nature and inherent sacrifices of military life and to attract and retain highly qualified members of the armed forces. The MHCB is directly tied to the overall morale of the member, and, therefore, is a critical part of the overall military compensation package.

The scope of this compensation package has increased and evolved following the Second World War to meet a changing demographic and social environment. These changes included (1) a peacetime active duty force of unprecedented size, (2) an increase in the number of retired members coupled with the increased life span of people in general, and (3) the development of employer-sponsored health care programs. Therefore, as access to medical care became related to an individual's job, Congress and the Department of Defense needed to provide similar benefits for the military family. [Ref. 37]

As discussed in Chapter IV, the evolution of the MHCB occurred in three phases. This chapter will determine the driving factors that influenced the MHCB in all three periods by focusing on congressional hearings. The testimony of special interest groups representing the military beneficiary and the statements of congressional members will be examined. The factors that led to the passage of the Dependents' Medical Care Act of 1956 and the Military Medical Benefits Amendments of 1966 will be determined. The "status quo" period will be examined to determine why Congress shifted its focus to containing the rising cost of CHAMPUS. And finally, the aggressive and expansive legislative and oversight period starting in the early 1980s will be examined to determine its driving factors.

B. FACTORS EXPLAINING THE PASSAGE OF THE DEPENDENTS' MEDICAL CARE ACT OF 1956

When World War II ended in 1945, the United States Military entered a period of rapid downsizing; however, the "new world order" that became known as the Cold War required a relatively large peacetime force to meet America's new national security requirements. Even though vast increases in the type and quality of medical care developed during the War, the active duty military family was only able to be treated at MTFs for acute medical and surgical conditions. By the early 1950s, DoD officials argued that medical care for dependents was a critical morale issue affecting the services. According to Assistant Defense Secretary John A. Hannah, "it has been established plainly that worry about the health of dependents and the availability of adequate care for them in times of sickness or accident has an adverse effect upon morale, particularly that of men separated from families while on duties overseas." Congress, recognizing the need to improve the MHCB, started to consider increasing the medical benefits offered to active duty members and their dependents. [Ref. 38]

Between 1950 and 1955, several bills were introduced in Congress that would have expanded the MHCB; however, strong opposition by the American Medical Association (AMA) and the American Hospital Association (AHA) killed the legislation in committee. It was these associations' belief that expanding military health care was akin to socialized medicine, thus making any modification politically unviable. However, in late 1955 and 1956 the AMA and the AHA dropped opposition to expanding the MHCB due to the generous medical benefits being offered in the private sector. [Refs. 39-42]

With the new support from the AMA and AHA, along with the continued support of the American Legion and the American Red Cross, Congress quickly worked with DoD officials to provide new and expanded benefits to the active duty and retired military family. Their intent was to remove the worry from the military

member (active or retired) that their dependents would be taken care of and to provide benefits at least equal to those offered in the private sector. In fact, the opening paragraph of the Dependents' Medical Care Act states that "the purpose of this Act is to create and maintain high morale throughout the uniform services by providing an improved and uniform program of medical care for members of the uniformed services and their dependents." One point that was disputed and did not become law was the inclusion of retirees and their dependents in the new Dependent Medicare program. This was omitted because the relatively low number of retirees at the time could easily be cared for at a MTF. [Refs. 12, 42, and 43]

C. FACTORS EXPLAINING THE PASSAGE OF THE MILITARY MEDICAL BENEFITS AMENDMENTS OF 1966

The Dependents' Medical Care Act of 1956 provided enhanced inpatient benefits at MTFs and the legal basis for dependent medical care in civilian hospitals. However, between 1956 and 1966 the benefits provided remained frozen at the 1956 level. This resulted in the gradual decline of the MHCB relative to the private sector. In the early 1960s, both DoD and Congress conducted studies to determine the state of military health care. The main areas of concern to DoD officials and members of Congress were the lack of outpatient services available and the lack of medical care for retirees and their dependents. [Ref. 43]

The issue of outpatient services was not new to Congress or DoD officials. In 1956, outpatient services were considered as part of the Dependents' Medical Care Act but were later dropped as an authorized benefit since outpatient care was not a common benefit given in the private sector. However, due to advances in medical technology, many types of cases, which in 1956 would have been treated as an inpatient basis, could now be treated as an outpatient service. In addition, most health insurance plans contained this benefit by 1966. [Ref. 44]

The other major concern was retirees and their dependents. The 1956 Act seemed to assure health care to retirees and their dependents at MTFs due to the relatively small number of these beneficiaries compared to the capacity of MTFs. However, due to the large number World War II service members (many with large families) retiring in the early 1960s and the buildup of active duty forces as a result of the Cold War, the MTFs were operating at capacity and many retirees found long delays in obtaining health care on a space available basis. [Ref. 43]

DoD stated that Congress had a moral obligation based on historical precedents to provide government-sponsored medical plans for retirees and their dependents. A congressional hearing validated this claim when Chairman Rivers of the House Special Subcommittee on Construction of Military Hospital Facilities stated that the government did have an obligation to provide medical care to military personnel and dependents and that much of this care will need to come from civilian sources due to the capacity limitations at MTFs.

Based on these statements, several bills were introduced to Congress to increase the MHCB to both active duty and retired military families. At hearings before House Armed Services Committee, DoD officials, Members of Congress, military retirees and dependents along with numerous special interest organizations including the AMA, AHA, Retired Officers Association, Reserved Officers Association, Air Force Sergeants Association, and the Fleet Reserve Association all stressed the need for expanding the MHCB to be at least equivalent to the private sector.

In particular, it was argued, the MHCB should be at least equivalent to the Federal Government Employee Health Plan (FGEHP), the benefits of which far exceeded those available to the military member. Another concern was the gap in medical care for retirees and their dependents after the passage of Medicare legislation in 1965. Eligibility for Medicare coverage begins at age 65; however,

most military retirees retire in their 40s and could not receive Medicare benefits upon retirement. Therefore, if access to a MTF was unavailable the military retiree was denied government sponsored health care. As a result of these hearings and similar hearings conducted in the Senate, Congress recognized the "fading promise" to retired military personnel, as well as the plight of dependents of active duty members who were located away from MTFs and passed the CHAMPUS program, to be effective the first day of 1967. [Refs. 43 and 45]

Congress did not intend that CHAMPUS should replace Medicare as a supplemental health care benefit to military retirees. Rather, it was a transition benefit created to provide retirees health care from the time they retired until age 65. In addition, the benefits provided under CHAMPUS were designed to be equivalent to the benefits provided under the FGEHP. Therefore, the creation of Medicare for individuals over 65 and the growth of the FGEHP directly led to the growth of the MHCB. [Ref. 45]

D. FACTORS EXPLAINING THE "STATUS QUO" ERA OF 1967 TO 1982

With the passage of the Medical Benefits Amendments of 1966, Congress created one of the most generous health care programs available. While the medical benefits were equivalent to those of other programs, the cost incurred by the member was not. Treatment at a MTF was free of charge, and CHAMPUS did not require a payment of monthly premiums. This new health care legislation created a feeling that the MHCB provided all required care and did not require additional modifications. This perception is clearly seen in the opening statement before the House Subcommittee on Supplemental Service Benefits in 1969. Chairman Byrne stated "this hearing constitutes the first congressional review made of the program [Medical

Benefits Amendments of 1966] since the increased benefits went into effect." [Refs. 15 and 46]

It took Congress three years to revisit the MHCB; however, the reason for the review was not to increase benefits but to examine its problems. As Chairman Byrne further stated, "we want to examine what problems have resulted from this major extension of the program and what steps have been taken to overcome these problems." The problems referred to were primarily related to the administrative operation of the CHAMPUS program. In testimony before the subcommittee the quality of health care received was described as "pretty good" by numerous associations, and the subcommittee's report stated that "the quality of care provided is excellent." The only major non-administrative problem was with medical officer retention. The Subcommittee directed DoD to solve the problem by administrative action. The rising cost of CHAMPUS was discussed for the first time, and Congress expressed concern to DoD that the costs needed to be controlled. [Refs. 46 and 47]

During the 1970s, the United States was in a serious economic recession. However, this recession had no impact on the growth of the MHCB. From 1970 to 1976, DoD did not raise any major medical issue with Congress. The general perception of the MHCB was that it provided all the services that the military beneficiary needed. In addition, the major associations representing military beneficiaries reported to Congress that the MHCB was the most meaningful benefit to the military family and that its success was only hampered by administrative inefficiencies. The one exception that started to show its influence was the shortage of military physicians. This shortage was described to a Subcommittee of the House Armed Services Committee as a potential disaster for the availability and quality of military health care by the Retired Officer Association. [Ref. 48]

Congress became increasingly concerned with the growth in the cost of CHAMPUS. From 1966 to 1975 the cost of the program increased over 300 percent.⁷ This increase was not associated with benefits derived but internal administrative inefficiencies that increased the cost of running the program. Congress, apparently satisfied that the military family was receiving quality health care, focused its efforts on the cost of CHAMPUS, something DoD seemed unable to do. [Ref. 49]

The first real concern that the quality of military health care was declining surfaced in 1979. At hearings before the House Subcommittee on Military Compensation, Chairman Nichols stated "...we have assigned the greatest priority to this subject [MHCB] because of the high value that is placed on health care as a benefit of military service and because of the recent, rapid deterioration observed in the delivery of military health care." He further stated "this deterioration has, in large part, been the result of a physician shortage." This shortage is a direct result of shifting to an all-volunteer military force in 1973. Prior to that, the military relied on the draft as the primary source of new physicians; with that source severed, the mix of required specialized physicians could not be obtained. Congress attempted to solve this program with new pay incentives to attract and keep qualified physicians. [Ref. 50]

In hearings before the Senate Armed Services Committee in 1980, the continuing cost of CHAMPUS was still the major issue, as well as DoD's inability to solve it. However, the quality of health care was still considered good. In his testimony before the Committee, Doctor Pirie, Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics, stated that the current shortage of

⁷The 300 percent growth in costs is not adjusted for inflation. However, this is the figure used in congressional hearings to describe the increasing costs of CHAMPUS.

physicians has created a perception that the MHCB has been eroding due to difficulty in gaining access to MTFs. He further stated that

in a world unconstrained by competing demands for scarce resources, we would all prefer more health care benefits for military dependents. But in view of current resource limitations and the primary mission for military medicine, we believe that the present level of dependents' health benefits is about right. Military dependents have health services equivalent to those available in the private sector, and active duty members are provided medical benefits far in excess those available to private sector workers.

Congress, believing that health care benefits were adequate for the military family, continued its focus on the cost of CHAMPUS. [Ref. 51]

In 1981 the first signs of a shift away from the focus on cost can be seen. More questions were being asked regarding the quality and adequacy of military health care. In particular, the "concerns" of military members about the availability of health care and questions from Congress about the quality of military health care to DoD officials started to increase. In hearings before the Senate Subcommittee on Manpower and Personnel, Chairman Jepsen voiced the complaints of service members and dependents about the lack of adequate medical and dental care to the Acting Secretary of the Army. Chairman Jepsen wanted to know what recommendations the Secretary had to enhance medical care at MTFs and the CHAMPUS program. He later stated "it is incumbent on us [Congress] to find new and innovative ways to improve our health care system." [Ref. 52]

In 1982, we see a clear shift in congressional intent and the end of the "status quo" era. Senator Inouye, speaking before the Senate Subcommittee on Manpower and Personnel stated "I strongly feel that high-quality health care for CHAMPUS beneficiaries is very much in our national security interest. It is the men and women

of our defense that actually protect our Nation. If they or their loved ones are not in the best of health, we are seriously jeopardizing our national security." He further stated "health benefits are not only just an incidental enticement for enlistment, I believe they are a fundamental investment for our entire Nation." [Ref. 53]

Further evidence of the shift came when the Chairman of the Senate Subcommittee on Manpower and Personnel, Senator Jepsen, stated that his subcommittee must put together comprehensive legislation to continue the positive trend in military pay and benefits (this includes the MHCB). Thus at the end of 1982, Congress began an active process to not only improve the MHCB but to provide the best possible care. [Ref. 54]

E. FACTORS EXPLAINING THE EXPLOSION OF LEGISLATIVE INITIATIVES AND DIRECTIVES FROM 1983 TO 1996

The growth of the MHCB after 1983 occurred as part of the annual Defense Authorization legislation, as opposed to separate legislation as occurred in 1956 and 1966. This is symptomatic of Congress as a whole. In the 1960s and 1970s, oversight was Congress' neglected function; however, by the 1990s, it was its dominant one. One reason for this policy shift was the continuing struggle with massive federal budget deficits. These budget deficits precluded Congress from creating many new programs. Therefore, legislative work on existing programs was the only substantive game in town. Another reason for increased oversight was divided government. With one political party in control of the legislature and the other controlling the executive branch, congressional distrust and skepticism of executive branch agencies magnified and oversight intensified. Congressional oversight expanded beyond its traditional role of monitoring a federal program and exposing mismanagement. This new role was to use oversight as a policy making tool. This is very important in understanding the growth of the MHCB and congressional involvement during this period. [Ref. 10]

This shift was seen with Senator Jepsen's Subcommittee on Manpower and Personnel. It was his Subcommittee that began to increase its oversight and involvement with the MHCB. In addition, 1983 saw the House Armed Services Committee not only hold hearings on the Fiscal Year 1984 Defense Authorization but on "Oversight of Previously Authorized Programs" as well. In 1985, the Senate Subcommittee on Manpower and Personnel, Chaired by Senator Wilson, started a series of oversight hearings on the military health care system. During these hearings the Committee expressed its serious concern that DoD's failure to implement changes in its administration of the military health care program had led to continued dissatisfaction among beneficiaries. In addition, Senator Glenn stated "I think that ensuring that the military health care system consistently provides the highest quality care is one of the most important oversight responsibilities of this subcommittee." [Refs. 55 and 56]

Another important development in 1985 was the union of the numerous organizations and associations that had testified over the years on behalf of the MHCB. This new union, the Military Coalition, was born at a time when Congress solicited opinions of outside organizations on the status of military health care. Senator Wilson, Chairman of the House Subcommittee on Manpower and Personnel, stated that the time has come to hear from witnesses outside the administration whose critical opinions arise from a different perspective [Ref. 56]. From 1985 on, this new coalition provided the subcommittees on Personnel with its evaluation of the MHCB and how it could be improved.

Another shift was in the priorities of compensation. Until the early 1980s, pay was always listed as the number one compensation priority among military members; however, after Congress significantly improved pay in 1981 and 1982, the MHCB became the number one compensation priority with military families [Ref. 57]. With

this shift of priorities among military families, Congress followed suit. Senator Glenn, as Chairman of the Senate Subcommittee on Manpower and Personnel, stated that the "quality of life" of our service members was his subcommittee's highest priority. By 1990 it was clear that Congress recognized the importance of the MHCB and would not allow it to deteriorate. While the growth of the MHCB indirectly increased retention, it was Congress's intent to preserve the quality of life of both the active duty and retired military family that was the deciding factor. [Refs. 56, 58, and 59]

From 1985 to 1996 the increased benefits that Congress authorized as part of its oversight were intended to make the program equivalent to health care benefits offered in the private sector. In the late 1980s and 1990s advances in medical technology (MRIs, lasers, laparoscopic surgery, etc.) and new types of medical delivery systems (HMOs) allowed more high quality specialized medical services to be offered [Ref. 60].⁸ As these services became available in the private sector, congressional members pressed for similar medical services for the military beneficiary. In testimony before the Committee on Armed Services, Senator Thurmond, seeking chiropractic benefits for military beneficiaries, stated that it was unfair for the deserving men and women in uniform to be denied benefits that were offered not only in the private sector, but also under Medicare and the FGEHP [Ref. 61]. From 1985 to 1996, Congress, aware of these increasing medical services available in the private sector, seemed determined to provide them to military beneficiaries. As a result, Congress authorized the necessary increases in benefits as part of the Defense Authorization legislation [Refs. 60, 61, 62, 63, and 64].

⁸While HMOs discourage the use of specialists in order to control costs, these new services are available and can be provided when recommended by the patient's primary physician.

However, aware of the increased costs involved in these new benefits and the continued cost escalation of CHAMPUS, Congress also directed DoD to initiate cost-saving programs. Congress' intent with programs such as TRICARE was to provide these new medical benefits, and to improve the quality of health care offered to the military beneficiary, without increasing the cost to the government [Ref. 36]. In this manner, Congress hoped to provide new benefits without directly increasing the overall cost of the MHCB.

VI. SUMMARY, CONCLUSIONS, AND FUTURE PROSPECTS

A. SUMMARY

This thesis explored and documented the changes to the military health care benefit and identified the principal drivers behind them. A 40 year review of the legislative changes to the MHCB was made to determine the scope of these changes and the reasons behind them. Specific objectives of this analysis were to:

- Determine the principal factors that have influenced Congress to change the scope of the MHCB for active duty military, dependents and retirees.
- Describe the congressional process used to change the MHCB.
- Determine what outside organizations have influenced congressional action on the MHCB.
- Determine if changes in Social Security, Medicare and/or Medicaid influence corresponding changes in the MHCB.
- Determine if shifting to an all volunteer military force affected the MHCB.

Chapter I provided the background on the MHCB. The chapter also indicated that the military health care benefit expanded from an "emergency care only" program for the active duty force into complete medical coverage for active duty members and their dependents, retired members and their dependents, and certain former members.

Chapter II began with an overview of the MHCB as it exists today. A detailed description of the classification of "military dependent" was given along with the type of medical and dental benefits available at MTFs. In addition, the TRICARE Family Member Dental Program (TFMDP), DoD's dental insurance plan for active duty

member's dependents, was discussed. Next, the major health insurance programs offered by DoD were introduced, along with a summary of eligibility for the MHCb available under current DoD programs. The remainder of Chapter II provided a detailed description of the various DoD health care insurance plans available to beneficiaries. This included both CHAMPUS and DoD's managed health care program known as TRICARE.

Chapter III introduced the legislative process and described how this process is used to change the MHCb. A detailed description of Congress, its structure, and its legislative process was presented to understand the playing field that Congress operates in. The specific House and Senate Committees and Subcommittees with jurisdiction over MHCb issues were identified. The emphasis of this chapter was the introduction of legislation affecting the MHCb. A discussion on how this legislation could be initiated, proposed, discussed in committee or subcommittee, marked-up and finally passed as a law provided insight into the congressional process of changing the MHCb.

Chapter IV provided a detailed, chronological description of the congressional action that modified the MHCb from 1956 to 1996. It identified three distinct periods of congressional involvement. Two of these three periods dealt with expanding medical benefits, while the third was primarily focused on cost control. United States Code, Title 10 (Armed Forces), was the principal reference for the changes that occurred in military health care. Chapter 55 (Medical and Dental Care) of Title 10 is the complete set of laws that provide statutory authority for the MHCb. Title 10 also contains a historical record of all previous changes made to the code.

The scope of this thesis and the large number of minor modifications made to the MHCb precluded the inclusion of minor changes in this analysis. The analysis

focused on the changes that had a substantial impact on the quality of health care received or the quantity of health benefits given.

Chapter V contains the analysis of the changes to the MHCB. In this chapter, the major changes to the MHCB were reviewed along with the associated influences that affected the change. Specifically, the rationale for congressional modification of the MHCB was addressed.

B. CONCLUSIONS

As shown in the previous chapters, factors that affect the MHCB are numerous and complex. These factors include rapid advances in medical technology, the growth and increasing benefits of private sector health insurance plans, the rising number of retired personnel, the political issue of "quality of life" for military families, the lobbying effect of outside organizations, and a desire of Congress to provide "better than the minimum" for the military family.

After a review of the military health care benefit covering 40 years, two general trends are revealed. The first is that Congress expanded not only the type of benefits but also the basis for eligibility to receive them. Secondly, the overwhelming reason that they chose to increase these benefits was equity. Whether it was the Dependents' Medical Care Act of 1956 or incremental increases during the late 1980s and 1990s, how the MHCB compared to those benefits received in the private sector was the primary driving factor in congressional action.

In 1955, one year before the first major increase in the MHCB, the American Medical Association (AMA), and the American Hospital Association (AHA) both reported to Congress that they did not support the proposed increases to the MHCB, which included an insurance plan, because it was akin to socialized medicine. This was the only time that any medical organization or association recommended against increasing the MHCB. As later discussed in Chapter V, the AMA and the AHA later

reversed their position and supported the new benefits. The primary reason for this change was equity. As the private sector increased its use of medical benefits as a non-wage incentive, the AMA and AHA could not argue that the government should not provide the same type of benefits for its employees.

As 1966 approached, it became clear to Congress that the MHCB had slipped below that of private sector programs. This information was provided by DoD officials and special interest groups such as the Retired Officers, Fleet Reserve, Air Force Sergeants, American Medical and American Hospital Associations. Not only had the MHCB slipped behind private sector benefits, but it also compared poorly to government programs. The medical benefits under the Federal Government Employee Health Plan (FGEHP) exceeded those available to the military family.

Similarly, passage of Medicare legislation created a "gap" in government sponsored health care for military retirees and their dependents. When Congress established Medicare, it did so to provide and guarantee health care to individuals after they reached retirement at age 65. However, since most military retirees are in their 40s when they retire, these retirees were not eligible to receive government health care for approximately 20 years. In order to correct this inequity between the military family and other sectors, Congress created the CHAMPUS program, as part of the Medical Benefits Amendments of 1966. Under this program, military retirees would be covered until the age of 65 and then would be shifted to Medicare. There is no evidence to support any claim that the other medical care program created in 1966, Medicaid, had any influence on the MHCB.

Equity can also be considered a factor in congressional inaction during the "status quo" era. With the passage of the Medical Benefits Amendments of 1966, Congress created one of the most generous health care programs available in the United States. Reports to Congress from DoD officials and numerous associations

validated the superior benefits received under the program. Because DoD, special interest groups, and military beneficiaries considered the MHCB to be equal to or greater than the private sector's benefits during this time, Congress took no action to increase benefits. Instead, Congress focused attention on the rising cost of CHAMPUS versus new programs and or benefits.

In 1969, Congress became concerned about reported inefficiencies in the administration of the CHAMPUS program. These inefficiencies created escalating costs, while benefits remained unchanged. Repeatedly, Congress directed DoD to take the steps necessary to increase the efficiency of the CHAMPUS program in order to control costs; however, DoD was unsuccessful in this tasking. This prompted Congress to concentrate its effort on the cost of CHAMPUS and to pass legislation that restricted the CHAMPUS benefit in an attempt to control the rising costs.

Another important factor explaining the inaction of Congress during the "status quo" era and its evolution to an active Congress in the 1980s and 1990s was Congress itself. This period in congressional history was one in which congressional oversight of programs was severely neglected. It was not until the early 1980s that Congress began to increase oversight, a function which later became a powerful congressional tool.

After 1982, Congress started to increase its oversight of the MHCB. An important consideration during this period was congressional skepticism of DoD's analysis of the MHCB and beneficiary satisfaction. Congress increasingly sought outside opinions to keep them informed of the military family's perception of military health care. In 1985, the Military Coalition was formed from the numerous associations that once lobbied Congress independently. This new coalition became the principal voice of the military health care beneficiary.

In the 1980s and 1990s, the medical profession experienced rapid changes in medical care technology. This new technology, which almost changed on a yearly basis, provided patients and doctors with new diagnostic and treatment options. Once available in the private sector, Congress sought to include these new services/benefits in Defense Authorization legislation.

Finally, there is the contention that the growth of the MHCB is due to the all-volunteer force. While it is true that military medical care benefits were used in recruitment campaigns, there is little evidence to support the claim that the growth of the MHCB was associated with the need to keep men and women in the military. There are references to retention and recruitment in testimony before the House and Senate; however, the issue was quality and availability of care, not increasing existing benefits. In fact, over the last 40 years, the largest and most significant increases in the MHCB occurred in 1956 and 1966. In both these years, the military draft was the primary source of military personnel.

C. FUTURE PROSPECTS

Since equity has been the driving factor influencing congressional action on the MHCB, it can be projected that benefits will continue to keep pace with that of the private sector. The Military Coalition will continue to provide Congress with proposed changes to the MHCB that would keep it equitable with other programs. The current political climate will still push for the "quality of life" for the military family. Cost is always a consideration with any new benefit; however, in testimony before the House and Senate Committees, DoD officials stated that cost savings from the CHAMPUS Reform Initiative and full implementation of TRICARE will help offset the costs of these new benefits.

D. SUGGESTIONS FOR FUTURE RESEARCH

This thesis examined congressional procedures and actions affecting the MHCB. It could be useful to compare the Executive Branch proposals for military health care in its annual budget and what was finally approved by Congress.

During the 1960s, the Federal Government Employee Health Plan (FGEHP) expanded and provided benefits unavailable to the military beneficiary. It wasn't until 1966 that the two programs offered similar benefits. It would be useful to determine why the FGEHP expanded in the early 1960s with no corresponding increases in the MHCB.

One area that this thesis did not explore was the role of the congressional staff with regard to policy making. It would be useful to determine if the growth of the congressional staff had a corresponding effect on Congress' oversight of the MHCB.

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